STATE OF MICHIGAN

COURT OF APPEALS

BARBARA WLOSINSKI, Personal Representative of the Estate of MICHAEL WROBEL, Deceased,

Plaintiff-Appellee,

and

BLUE CROSS BLUE SHIELD OF MICHIGAN and BLUE CARE NETWORK OF MICHIGAN,

Intervening Plaintiffs,

v

STEVEN COHN, M.D., and WILLIAM BEAUMONT HOSPITAL,

Defendants-Appellants.

FOR PUBLICATION
December 20, 2005
9:15 a.m.

No. 253286
Oakland Circuit Court
LC No. 2001-033241-NH

Official Reported Version

Before: O'Connell, P.J., and Schuette and Borrello, JJ.

O'CONNELL, P.J.

In this medical malpractice wrongful death case, defendants appeal as of right a judgment in favor of plaintiff. We reverse the trial court's denial of defendants' motion for summary disposition on plaintiff's claim of lack of informed consent, vacate the trial court's judgment, and remand for a new trial.

In May 1998, the decedent, Michael Wrobel, was diagnosed with kidney failure. At the time of diagnosis, he was a senior in high school. Medical testing confirmed that plaintiff, the decedent's mother, would be a suitable kidney donor. The decedent and his mother researched various hospitals and discovered that defendant William Beaumont Hospital had a high success rate for kidney transplants according to mandatory reports that were posted on the website of a national organization. They visited the hospital and were introduced to defendant Dr. Steven Cohn, who explained the procedure. On July 14, 1999, Dr. Cohn transplanted one of plaintiff's kidneys to the decedent. The decedent suffered severe postoperative complications, including a blood clot in the blood vessel feeding the transplanted kidney. Dr. Cohn removed the clot, but the transplanted kidney ultimately failed anyway. Doctors removed the failed kidney, and the

decedent resumed kidney dialysis. The decedent's health continued to decline over the next year, and he ultimately elected to withdraw from kidney dialysis and entered a hospice program. He died on September 24, 2000.

On July 13, 2001, plaintiff filed a medical malpractice wrongful death action against defendants. Plaintiff's original complaint alleged that defendants committed several errors related to the blood clot that appeared after the operation. Plaintiff amended the complaint to include a count for defendants' failure to garner plaintiff's and the decedent's informed consent. Plaintiff based this count on an alleged discrepancy between the hospital's reported success rate for kidney transplants, which she apparently found while researching hospitals, and its actual success rate. She also alleged a discrepancy between the personal success rate Dr. Cohn reported to her and his actual success rate. Plaintiff did not support this amended complaint with an affidavit of merit. Nevertheless, plaintiff again moved to amend her complaint, and the proposed amendments alleged that the negligent use of drugs that suppressed the decedent's immune system led to an infection that caused the kidney to fail. The trial court allowed the amendment, but insisted that plaintiff include an affidavit of merit for the additional counts.

The version of the amended complaint that plaintiff filed differed from the version she attached to her motion to amend. It included additional allegations regarding the negligent use of mesh in the decedent's blood clot operation to hasten healing of the surgical wound. It alleged that the use of mesh led to an infection that compromised the kidney. Plaintiff presented an affidavit of merit from her expert, Raymond Pollak, M.D., who confirmed that defendants' management of the original surgery, their discovery of the blood clot, and its removal failed to conform to the standard of care. Dr. Pollak also ventured his opinion that defendants made the following nontechnical omissions:

> i. Failure to address deficiencies in the transplant department . . . and to correct whatever disagreements there were between the transplant team . . . so as to insure proper communications between them and appropriate treatment of the Plaintiff's decedent . . . [.]
>
> j. Failure to investigate/retrain/dismiss incompetent transplant physicians/surgeons . . . which may have prevented the adverse outcomes that occurred . . . [.]
>
> k. Failure to investigate Dr. Cohn's higher than average transplant surgical failure rate in a timely manner and to inform the Plaintiffs of the same [.]

Defendants moved for summary disposition, claiming that plaintiff failed to substantiate any of her claims. Defendants specifically argued that plaintiff's claim of lack of informed consent lacked any factual support because plaintiff's deposition testimony indicated that she was informed of the risks associated with the transplant procedure. The trial court denied the motion, stating that defendants had failed to counter the statement in Dr. Pollak's affidavit that the statistical information withheld from plaintiff and decedent failed to conform to the standard of care. The case proceeded to trial.

At trial, the court allowed plaintiff to present the evidence of Dr. Lawrence Greenberg, who was not certified in Dr. Cohn's specialty, but who repeatedly denigrated Dr. Cohn's surgical abilities primarily on the basis of a string of failed transplants. Dr. Greenberg's testimony harped on Dr. Cohn's failure rate leading up to the decedent's surgery. Dr. Greenberg testified that five out of seven of Dr. Cohn's kidney transplants had failed in the months before the decedent's surgery. When the defense tried to shed some light on the circumstances surrounding the failed transplants, the trial court correctly ruled that privilege precluded plaintiff from obtaining and presenting details of Dr. Cohn's failures, so it would not allow the evidence. Under these circumstances, the statistics remained raw numbers without any factual development that might suggest a correlation between the other failed transplants and the decedent's transplant. Plaintiff's experts made further comments about Dr. Cohn's failure rate, and plaintiff's counsel emphasized the sequence of failed transplants in his closing arguments. The jury awarded plaintiff $1.475 million in damages, and the trial court, after making relatively minor adjustments, entered judgment for roughly $1.5 million.

Defendants contend that the trial court erred in denying their motions for summary disposition and judgment notwithstanding the verdict on plaintiff's claim that Dr. Cohn failed to obtain the decedent's informed consent before surgery. According to defendants, a physician has no duty to disclose to a patient the physician's success rates for a particular medical procedure, and Dr. Cohn's failure to advise the decedent of his success rates could not, as a matter of law, taint the patient's consent. We agree. We review de novo a trial court's decision to grant summary disposition. *Maiden v Rozwood*, 461 Mich 109, 118; 597 NW2d 817 (1999).

The doctrine of informed consent requires a physician to warn a patient of the risks and consequences of a medical procedure. *Lincoln v Gupta*, 142 Mich App 615, 625; 370 NW2d 312 (1985). By itself, Dr. Cohn's success rate was not a risk related to the medical procedure. *Id*. In fact, none of the affidavits of merit accompanying plaintiff's complaints indicates that disclosure of Dr. Cohn's particular success rate was necessary to obtain informed consent according to the standard of care. As a matter of law, we hold that a physician's raw success rates do not constitute risk information reasonably related to a patient's medical procedure.[1]

The other jurisdictions that have addressed similar issues agree. See *Howard v Univ of Medicine & Dentistry of New Jersey*, 172 NJ 537, 553-554; 800 A2d 73 (2002), and the cases it cites. Although many jurisdictions recognize only deceit-based claims or no claim at all, see *Duttry v Patterson*, 565 Pa 130, 136-137; 771 A2d 1255 (2001); *Ditto v McCurdy*, 86 Hawaii 84, 90-91; 947 P2d 952 (1997), some jurisdictions have allowed evidence about a doctor's inexperience, but only in cases in which the doctor asserted his or her experience and

[1] Our holding is limited to the disclosure of statistical data regarding past treatment and other background information that has no concrete bearing on the actual risks of a given procedure. Certainly if a surgeon unfailingly faints at the sight of blood, a reasonable patient might want to know this and explore other treatment options. Between these poles, however, lies a world of scenarios that requires trial courts to remain vigilant in their roles as evidentiary gatekeepers. MRE 702. The trial court did not exercise that role in this case.

competence; see *Howard, supra* at 558-559; *Johnson v Kokemoor*, 199 Wis 2d 615, 624; 545 NW2d 495 (1996). Even those jurisdictions do not require wholesale statistical disclosure, but approach a doctor's qualifications as they relate to the procedure's particular risks, an ordinary patient's willingness to accept those risks in light of the alternatives, and the causal connection between the disclosure and the actual harm. *Howard, supra*; *Johnson, supra*. For example, although the Wisconsin court in *Johnson* allowed the statistical evidence to stand, it specifically warned against the adoption of a standard of care that universally required statistical disclosure. *Johnson, supra* at 645-646. Moreover, the New Jersey court in *Howard* did not automatically sanction a probe into the doctor's experience, but remanded the case so that the trial court could perform its "gatekeeper function," which it defined as a "significant" role assigned "to prevent insubstantial claims . . . from proceeding to a jury." *Howard, supra* at 558. Emphasizing the causation standard, the court stated, "We contemplate that misrepresented or exaggerated physician experience would have to significantly increase a risk of a procedure in order for it to affect the judgment of a reasonably prudent patient in an informed consent case." *Id.* The court specifically noted that New Jersey has never placed a duty on doctors "to detail [their] background[s] and experience[s] as part of the required informed consent disclosure . . . ." *Id.* at 554.

In this case, plaintiff's deposition reflected that Dr. Cohn vaguely represented his transplant history as "good,"[2] and that he otherwise informed plaintiff and the decedent of the medical risks that were directly related to the surgery. Therefore, we do not even approach the type of misrepresentation that may urge a contrary result. Also, unlike the cases involving misrepresented experience, this case lacks any hint of a relationship between Dr. Cohn's previous failed transplants and the failure of the decedent's new kidney.[3] Without a compelling case before us, we simply hold that defendants, as a matter of law, did not have a duty to disclose Dr. Cohn's statistical history of transplant failures to obtain the decedent's informed consent.

Regarding plaintiff's other uses of this statistical evidence, our courts have long recognized the distinction between a doctor's negligence and a treatment's failure. *Roberts v Young*, 369 Mich 133, 138; 119 NW2d 627 (1963). "[T]he bare fact that full recovery does not result, or that a surgical operation is not entirely successful, is not in itself evidence of negligence." *Id.*, quoting *Zoterell v Repp*, 187 Mich 319, 330; 153 NW 692 (1915). Therefore, bare numerical success rates are not, in themselves, evidence that a doctor did anything wrong. For example, it is absolutely unknown, and unknowable, whether the preceding kidney transplants performed by Dr. Cohn failed because of health complications that rendered those

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[2] In fact, the evidence reflects that at the time of these statements, Dr. Cohn's success rate was very good.

[3] On this point, it should be noted that the clearest definition of a "failed" transplant, which underlay the controversial statistic, was the loss of the transplanted organ, for any reason, within a year. As defendants pointed out below, "any reason" might include a car accident or some other totally unrelated happenstance. Therefore, the bare statistics were totally unrelated to the risks of transplant surgery and could never satisfy the criterion of actually causing the injury here.

patients "high risk" patients.[4] We will not permit an inference of negligence to flow from unsuccessful treatment alone. *Roberts*, *supra* at 138. Yet, by allowing the limited inclusion of the mere existence of these transplant failures, the court allowed the jury to conclude that Dr. Cohn had a proclivity to fail. Because the bald statistics are not valid evidence of negligence either by Dr. Cohn or by the hospital, and because they are not relevant to informed consent,[5] we fail to see what purpose they serve other than as prohibited character evidence. MRE 404(b)(1).

There can be no doubt that plaintiff's counsel paraded the statistics before the jury to show that Dr. Cohn had a propensity to botch transplants. Propensity evidence is barred because it diverts a jury's attention from the facts of the case being tried and focuses it on the probability that the defendant, who has made so many mistakes before, made one again. Cf. *People v Matthews*, 17 Mich App 48, 51-52; 169 NW2d 138 (1969). In other words, it punishes a defendant for his misfortune rather than his fault. The ploy worked especially well in this case, because the details and circumstances of the previous surgeries were kept from the jury, and the jury was not instructed to limit its use of the invalid evidence. This evidence fatally tainted the jury's verdict, and a new trial is in order. MRE 103.

Defendants also raise several challenges to plaintiff's experts, but because we remand for a new trial, it is unnecessary to resolve all these issues here. Nevertheless, we agree with defendants that the trial court failed to perform its gatekeeping mission under *Craig v Oakwood Hosp*, 471 Mich 67, 78-81; 684 NW2d 296 (2004), and MRE 702. On remand, the court should hold a hearing and evaluate the factual and medical underpinnings of Dr. Pollak's anticipated testimony. We also note that neither Dr. Greenberg nor Dr. Evan Morton was qualified to testify against Dr. Cohn regarding the standard of care because they were not board-certified in the same specialty as Dr. Cohn. MCL 600.2169. Their evidence should be limited accordingly. The trial court must also examine the relevance of Dr. Greenberg's testimony apart from the invalid statistical information he provided at trial and carefully review it for probative value and relevance to the decedent's surgery. It should go without saying, however, that we do not bar Dr. Greenberg from providing other, admissible testimony. Similarly, Dr. Morton's testimony did not exclusively relate to whether Dr. Cohn breached the standard of care; it also related to a Doppler ultrasound performed on the night of the transplant. Expert testimony is admissible under MRE 702 if (1) the expert is qualified, (2) the testimony assists the trier of fact to understand the evidence or determine a fact in issue, and (3) the testimony is derived from recognized scientific, technical, or other specialized knowledge. *Craig*, *supra* at 78-79. Without

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[4] We note that one of the foreseeable consequences of requiring doctors, especially surgeons, to disclose their success rates as a condition to our deeming a patient's consent "informed" is that it would encourage doctors to treat only those patients who will likely boost their success rates, rather than the frail, "high risk" patients who truly and desperately need the specialized care that doctors offer.

[5] Pennsylvania recognizes that facts failing to support a claim of lack of informed consent might support a claim of fraud, *Duttry*, *supra* at 137, but neither the pleadings nor the particulars of this case support a fraud claim here, so we do not examine this as an alternative.

deciding the issue, it appears to us that Dr. Morton's testimony may be relevant to plaintiff's theory of the case.

Finally, defendants argue that the trial court erred in refusing to cap plaintiff's monetary award for wrongful death damages regarding the decedent's funeral and burial expenses and plaintiff's loss of society and companionship. Because we are remanding for a new trial, we merely note that "the medical malpractice noneconomic damages cap does apply to wrongful death actions where the underlying claim is medical malpractice . . . ." *Jenkins v Patel*, 471 Mich 158, 161; 684 NW2d 346 (2004). The parties should approach the case accordingly.

Denial of summary disposition reversed in part, judgment vacated, and case remanded for new trial. We do not retain jurisdiction.

/s/ Peter D. O'Connell